OMB #: 0938-0707
Exp. Date:

MODEL APPLICATION TEMPLATE FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Preamble

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner. To be eligible for funds under this program, states must submit a state plan, which must be approved by the Secretary. A state may choose to amend its approved state plan in whole or in part at any time through the submittal of a plan amendment.

This model application template outlines the information that must be included in the state child health plan, and any subsequent amendments. It has been designed to reflect the requirements as they exist in current regulations, found at 42 CFR part 457. These requirements are necessary for state plans and amendments under Title XXI.

The Department of Health and Human Services will continue to work collaboratively with states and other interested parties to provide specific guidance in key areas like applicant and enrollee protections, collection of baseline data, and methods for preventing substitution of Federal funds for existing state and private funds. As such guidance becomes available, we will work to distribute it in a timely fashion to provide assistance as states submit their state plans and amendments.

MODEL APPLICATION TEMPLATE FOR
STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: *ARKANSAS*
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, **(42 CFR, 457.40(b))**

Roy Jeffus, Director, DMS (Signature of Governor, or designee, of State/Territory, Date Signed)

submits the following State Child Health Plan for the State Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved State Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following state officials are responsible for program administration and financial oversight **(42 CFR 457.40(c))**:

Name: *Kurt Knickrehm* Position/Title: *Director, Department of Human Services (DHS)*
Name: *Roy Jeffus* Position/Title: *Director, DHS Division of Medical Services (DMS)*
Name: Position/Title:

Section 1. General Description and Purpose of the State Child Health Plans and State Child Health Plan Requirements **(Section 2101)**

1.1 The state will use funds provided under Title XXI primarily for (Check appropriate box) **(42 CFR 457.70)**:

1.1.1. ☐ Obtaining coverage that meets the requirements for a separate child health program **(Section 2103)**; **OR**

1.1.2. ☐ Providing expanded benefits under the State's Medicaid plan **(Title XIX)**; **OR**

1.1.3. ☒ A combination of both of the above.

A. Background

Arkansas has aggressively pursued health care for children by covering optional benefits and categories that benefit children and developing Medicaid 1115 demonstrations. For example, Arkansas has elected to provide the full range of EPSDT services to children without requiring the EPSDT screen. Also Arkansas was one of the first states in the nation to cover the TEFRA-134 children, authorized by the Tax Equity and Fiscal Responsibility Act of 1982.

Effective 1-1-03, the State began covering TEFRA children in a TEFRA-like 1115 demonstration in which the parents pay a premium based on a sliding scale; some parents are not required to pay a premium. The TEFRA-like demonstration provides for the care of a child in its home, if he/she would qualify for Medicaid as a resident in a Title XIX institution, e.g., a nursing facility or an Intermediate Care Facility for the Mentally Retarded, etc. Parental income and resources are not counted in the child's eligibility determination, however parental income is counted in the premium amount calculation. The eligibility income limit for this demonstration is three times the SSI limit. The TEFRA-like 1115 demonstration makes Medicaid available to a large segment of the state's chronically ill children.

In its quest to provide health care for children, the State also opted to cover uninsured children through a Medicaid 1115 demonstration, ARKids First. This demonstration is discussed in item B, below.

SCHIP Phase I, a Medicaid expansion, was approved August 6, 1998 and implemented October 1, 1998. This was a small SCHIP Medicaid expansion in which the last of the eligible children aged-out of the program September 30, 2002. SCHIP Phase II is a separate SCHIP program that was approved February 16, 2001 but not implemented. Phase III supersedes Phase II. Phase III will cover some of the children in the State's Medicaid 1115 demonstration, ARKids B, as an SCHIP Medicaid expansion and cover unborn children as a separate child health program.

B. ARKids First Background and Development

In 1997, Arkansas' Governor, the Arkansas State legislature, the President and Congress were all addressing the issue of health care for vast numbers of uninsured children. Governor Mike Huckabee supported enabling state legislation and an appropriations bill in the 1997 legislative session that created and funded ARKids First, a Medicaid 1115 demonstration. The Arkansas Legislature passed both bills and Governor Mike Huckabee signed both bills into law by on March 10, 1997 (see Attachments A and B). Effective August 4, 2000, the 1115 demonstration was renamed ARKids B.

Ray Hanley, then Director, Division of Medical Services (DMS), formed and chaired an ARKids First work group, which was composed of individuals from the following: the Governor's Office (the Department of Human Services liaison), Arkansas Children's Hospital, Arkansas Department of Health, Catholic Social Services, Arkansas Advocates for Children and Families, Easter Seals, Communities in School of Arkansas, Arkansas Chapter for American Academy of Pediatrics, Electronic Data Systems (Arkansas Medicaid's fiscal agent), and various individuals in the Department of Human Services (DHS), including Tom Dalton, then Department Director. The first meeting was held February 7, 1997, one day after President Clinton announced his FFY98 budget package which included a proposal to expand health insurance access for poor children in families that earn too much for Medicaid but not enough to afford private health insurance. Additional ARKids First meetings were held as needed. Most of the discussion and concerns involved eligibility factors and the benefit package.

The Arkansas legislation, though not as detailed, mirrors the SCHIP legislation in its purpose, i.e., to provide health insurance coverage for uninsured children under 19 whose family income is at or below 200% of the poverty level. The ARKids First program was designed as an SCHIP program, but used the Medicaid 1115 demonstration process for implementation since the SCHIP legislation had not been passed at the time Arkansas' program was under development. The ARKids First Medicaid 1115 demonstration was approved by CMS on August 19, 1997 and implemented on September 1, 1997; only days after the SCHIP legislation was signed by the President.

The State developed the ARKids First Program with the thought that it would be able to roll the ARKids First Medicaid 1115 demonstration into an SCHIP program. However, the State recognizes that as the ARKids First (now ARKids B) Medicaid demonstration and the SCHIP legislation were developing, they didn't make completely parallel steps. Therefore, ARKids B enrollees, who do not meet the definition of an SCHIP targeted low-income child, will continue to receive their health care services through Title XIX federal funding. Children in ARKids B who meet the definition of an SCHIP targeted low-income child may receive their services through either Title XIX

or Title XXI federal funding, at the discretion of the State. All of the ARKids B children will remain in the Medicaid 1115 demonstration regardless of the funding source. The children who do not meet the definition of an SCHIP targeted low-income child are the children of state employees and the children who meet the eligibility requirements for regular Medicaid.

The ARKids First application form and the promotional materials identify the program as ARKids First. (Effective August 4, 2000, ARKids First became an umbrella for ARKids A, regular children's Medicaid, and ARKids B, the 1115 demonstration.) Applications may be made by mail, and a toll free number is available to clients. Applications in English or Spanish may be printed from the ARKids First web site at www.arkidsfirst.com.

The ARKids B benefit package and copayments are comparable to insurance offered to state employees. The State elected a copayment as the only cost sharing requirement, because it is the most equitable form of cost sharing. The State did not want to assess an enrollment fee nor monthly premiums because it wanted the family's cost sharing responsibility to be related solely to usage. The State will keep the current copayment structure in place for ARKids B enrollees without regard to the funding source (XIX or XXI).

The application form, the benefit package, and the identification card will be the same for all ARKids B enrollees without regard to the funding source.

It is possible for Arkansas to pursue this SCHIP Medicaid expansion for the ARKids B 1115 demonstration because section 2110(b)(II) of the SCHIP legislation and CMS Q&A 14(a) provide that states, which expanded Medicaid through an 1115 demonstration after June 1, 1997 may claim the enhanced match rate for such children. The ARKids B program was implemented on September 1, 1997.

C. Overview of ARKids B 1115 Demonstration (Medicaid and SCHIP)

The Arkansas Department of Human Services administers regular Medicaid and the ARKids B demonstration, which will be funded by Titles XIX and XXI.

The essential elements of the ARKids B program, without regard to the funding source, are as follows:

- *Covers children under 19.*
- *Family income must be at or below 200% of the poverty level.*
- *There is no asset test.*
- *Children must have been uninsured for the preceding 6 months or insurance was lost through "no-fault" such as parent is no longer employed and health insurance was lost.*

- *The benefit package is the Secretary approved Medicaid 1115 demonstration benefit package granted for ARKids B. The benefit package will be the same for all ARKids B enrollees without regard to the funding source.*

- *Cost-sharing is required for services that are not categorized as well-health.*

Notes: *Generally, in this document, the 1115 demonstration is referenced as ARKids B, even though it was known as ARKids First until August 4, 2000.*

The Division of Medical Services (DMS) and the Division of County Operations (DCO) are divisions of the Department of Human Services. DMS is responsible for the administration of the Medicaid and SCHIP programs except for eligibility, which is the responsibility of DCO.

The SCHIP definition of a targeted low-income child excludes children of state employees and children who meet the eligibility criteria for regular Medicaid, however these children are covered in the ARKids B program. The State will not use Title XXI funding for these children.

D. Overview of Unborn Child

The Arkansas Department of Human Services administers the SCHIP unborn child program.

The essential elements of the program are:

- *Medical verification of the pregnancy is required.*

- *Applicant must have no other insurance that covers the pregnancy.*

- *Net income must be at or below 200% FPL.*

- *The resource limit is the same as the resource limit for the SOBRA pregnant women category under Medicaid.*

- *The benefits will be the same as the SOBRA pregnant women category under Medicaid.*

1.2 Please provide an assurance that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS. **(42 CFR 457.40(d))**

The State assures that expenditures for child health assistance will not be claimed prior to the time that the State has legislative authority to operate the State plan or plan amendment as approved by CMS.

1.3 Please provide an assurance that the state complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35. **(42CFR 457.130)**

The state assures that it complies with all applicable civil rights requirements, including title VI of the Civil Rights Act of 1964, title II of the Americans with Disabilities Act of 1990, section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, 45 CFR part 80, part 84, and part 91, and 28 CFR part 35.

1.4 Please provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this plan or plan amendment **(42 CFR 457.65)**:

Effective date: *Medicaid expansion – Phase I: 10-1-98*
Separate State SCHIP – Phase II: Not Implemented
Medicaid expansion (ARKids B) - Phase III: 1-1-01
Unborn Child Coverage – Phase III: 7-1-04.

Implementation date: *Medicaid expansion – Phase I: 10-1-98*
Separate State SCHIP – Phase II: Not Implemented
Medicaid expansion (ARKids B) - Phase III: The State implemented retroactively to 1-1-01.
Unborn Child Coverage – Phase III: The target implementation date is July 1, 2004.

Section 2. General Background and Description of State Approach to Child Health Coverage and Coordination (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in 42 CFR 457.10). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements). **(42 CFR 457.80(a))**

A. Children Covered by Department of Human Services (DHS) Programs

As of the October/December 2003 quarter, there were 274,062 children enrolled in regular Medicaid. The racial break out is as follows: 154,695 (56.5%) white; 90,294 (33%) black; 16,205 (6%) Hispanic; 596 (.3%) Native American; 946 (.4%) Asian; and 11,326 (4.2%) other and unknown. The poverty level breakout shows that 91.7% were below poverty while only 8.3% were above the poverty level.

There were 64,065 children enrolled in the ARKids B category as of the October/December 2003 quarter. The racial breakout is as follows: 45,818 (71.5%) white; 14,121 (22%) black; 3002 (4.7%) Hispanic; 131 (.2%) Native American; and 772 (1.2%) other and unknown. The poverty level breakout shows that 11.1% are at or below the poverty level and 88.9% are above the poverty level.

Please see Attachments C and D for the racial breakout by age for regular Medicaid categories and for ARKids B, respectively.

Attachments E and F show eligibles by age by county for regular Medicaid categories and for ARKids B, respectively, for the October-December 2003 quarter.

Attachments G and H show a breakout of expenditures by State Category of Service for regular Medicaid categories and for ARKids B, respectively for the October-December 2003 quarter.

B. SCHIP

Phase I, was implemented 10-1-98. Phase I was a Medicaid expansion, which added children under 19 born after 9-30-82 and before 10-1-83. The last child aged out of the Medicaid expansion on 9-30-02.

Phase II, a separate SCHIP, was approved 2-16-01, but was not implemented. The separate state SCHIP would have covered a portion of the ARKids B children.

Phase III, is a combination program: The Medicaid expansion is a subset of the ARKids B Medicaid 1115 demonstration (implemented retroactively to 1-1-01); the separate child health program covers the unborn child. Phase III supersedes Phase II.

C. Discussion of Creditable Health Coverage

Arkansas has located two studies relevant to this issue. Information from each study is listed below:

1. *According to data from the Casey Foundation, based on their annual surveys (1992 through 1996 were combined in order to have a valid sample), Arkansas had 352,800 children (under 18) who were at or below 200% of the Poverty Level. Their data further shows that 112,700, or 32%, were uninsured children. We think the number of uninsured is high because we have been adding one year of eligible children each year to the Pregnant Women, Infants and Children category during the course of the five survey years used in their estimates.*

2. *According to the Southern Institute on Children and Families "Uninsured Children in the South-Second Report" dated November 1996, there are 99,752 uninsured children, under 18, in Arkansas who are at or below 200% of the Poverty Level.*

   The source of the estimates of uninsured children is the Current Population Survey. Uninsured means the lack of any health insurance, including Medicaid, for an entire year. The data were prepared by the Urban Institute using data specifications submitted by the Southern Institute on Children and Families for 1989 and 1993.

D. Public-Private Partnerships

The State does not have a public-private partnership. The State does not have a BC/BS Caring Program for Children.

2.2. Describe the current state efforts to provide or obtain creditable health coverage for uncovered children by addressing: **(Section 2102)(a)(2) (42CFR 457.80(b))**

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e., Medicaid and state-only child health insurance):

Medicaid

The State has been extremely active in its effort to identify and enroll uncovered children who are eligible to participate in the Arkansas Medicaid Program.

The State has cooperative agreements with 35 hospitals, clinics, and organizations throughout the state to place out-stationed DHS Medicaid eligibility workers in their facilities. This has simplified the application process and has encouraged individuals and families to apply for Medicaid when otherwise they might not have done so.

DHS also has an agreement with the Federally Qualified Health Centers for 19 staff who cover their 36 sites. These FQHC staff members assist in the application process.

Medicaid outreach is also furthered by a contract between the Arkansas Department of Human Services and the Arkansas Department of Health (ADH) for ConnectCare, the Arkansas Primary Care Case Management program. ConnectCare provides outreach through statewide television and radio advertisements to inform both current eligibles and potential eligibles about the merits of primary medical coverage through Arkansas Medicaid.

DHS also has an agreement with ADH to establish Presumptive Eligibility for Pregnant Women in the SOBRA category. Arkansas was one of the first states in the nation to employ the Presumptive Eligibility process for this group.

State-only Child Health Insurance

The State does not have any State-only child health insurance programs.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public-private partnership:

The State does not have a public-private partnership. The State does not have a BC/BS Caring Program for Children.

2.3. Describe the procedures the state uses to accomplish coordination of SCHIP with other public and private health insurance programs, sources of health benefits coverage for children, and relevant child health programs, such as title V, that provide health care services for low-income children to increase the number of children with creditable health coverage. *(Previously 4.4.5.)* **(Section 2102)(a)(3) and 2102(c)(2) and 2102(b)(3)(E)) (42CFR 457.80(c))**

Children currently covered in the 1115 demonstration, ARKids B, will be covered for health coverage funded through Title XIX or Title XXI.

Targeted to Uninsured Children

The ARKids B program is designed to provide health insurance coverage for uninsured children under age 19. Uninsured is defined as not having group or employer sponsored primary comprehensive health insurance within the previous 6 months, unless such insurance was lost through no-fault. An example of no-fault would be if the child(ren) had had health insurance through a parent's employment and the parent is no longer employed. Also children who have inaccessible health insurance are considered to be uninsured. For example, a child has inaccessible health insurance if the child has an out of state, non-custodial parent with HMO insurance for his/her child(ren) but the HMO network does not contain medical providers where the child resides.

Coordination With Medicaid

On August 4, 2000 Arkansas began using the ARKids First name as an umbrella for the 1115 demonstration and certain Medicaid categories. ARKids First is divided into ARKids A, regular Medicaid, and ARKids B, the 1115 demonstration (to be funded by Titles XIX and

XXI). The application form is an ARKids First umbrella application, which asks applicants to check one of three blocks to show their application preference - either ARKids program, ARKids A only, or ARKids B only. The application form contains a chart, which shows the services and cost sharing requirements in each program. The same chart is used for reapplications. Parents are not required to receive regular Medicaid for their children, if they prefer to receive ARKids B. Children in ARKids B, who are eligible for regular Medicaid, will not be funded by Title XXI.

The following is paraphrased from Arkansas Medical Services Policy Manual Policy Directive Number MS 00-8 dated August 4, 2000:

A. *If the applicant selects "ARKids A", "either", or makes no selection, then eligibility will be pursued for ARKids A (regular Medicaid); if the applicant is not eligible for ARKids A, the applicant's eligibility will be determined for ARKids B (the 1115 demonstration).*

B. *If the applicant selects "ARKids A only" and the children are eligible for ARKids A, then the children will be certified as ARKids A.*

   However if the applicant selects "ARKids A only" and the children are not eligible for ARKids A but they are eligible for ARKids B, the caseworker will take the following steps:

   1. *Attempt to contact the applicant immediately by phone. Inform the applicant that the children are not eligible for ARKids A but are eligible for ARKids B and ask if he or she would like to receive ARKids B.*
   2. *If the caseworker cannot reach the applicant by phone, a form letter will be mailed giving the applicant 15 days to respond if he/she wants to receive ARKids B for the children.*
   3. *Dispose of the application upon receipt of the information from the applicant or after 15 days from the date the form letter was sent, whichever occurs earlier.*
   4. *If the applicant declines ARKids B coverage or doesn't respond within the 15 day notice period, the application will be denied.*

C. *If the applicant selects "ARKids B only," the worker will determine eligibility for ARKids A and ARKids B. If the children are eligible for ARKids A, which would provide more coverage, the caseworker will take the following steps:*

   1. *Attempt to call the applicant immediately. Inform the applicant that the children are eligible for ARKids A and that it provides more coverage than ARKids B. Ask the applicant to again specify which coverage he or she prefers the children to receive. If the applicant states that he or she does want ARKids A then the application will be certified for ARKids A. If the applicant refuses ARKids A, a notice will be sent stating that the children have been approved for ARKids B but are eligible for ARKids A. The notice will also inform the applicant that if he or she changes his or her mind within 30 days and would prefer to receive ARKids A, to contact the worker who can approve the children in ARKids A without a new application.*
   2. *If the applicant cannot be reached by phone, a form letter will be sent giving the applicant 15 days to respond if he or she wants ARKids A for the children.*

3. *The worker will dispose of the application upon receipt of the information from the applicant or after 15 days from the date the form was sent, whichever occurs earlier.*
4. *If the applicant does not respond, the children will be certified as ARKids B.*

Note: ARKids B will be funded by Titles XIX and XXI. Title XXI will only be used for those ARKids B children who meet the SCHIP definition of a targeted low-income child.

Coordination with Children's Medical Services

The Department of Human Services operates a Children's Medical Services Program which provides care coordination and/or specialized medical care and rehabilitation for children with special health care needs whose families are partially or wholly unable to provide for such services and who meet the agency's criteria. Children's Medical Services are funded by federal (Title V) and state funds. The Children's Medical Services staff coordinate closely with Medicaid/SCHIP, especially with regard to the TEFRA-like Medicaid 1115 demonstration, to ensure that the children they serve receive the widest range of services to which they are entitled. Please reference Section 1.1.3.A., for more information regarding the TEFRA-like demonstration.

Coordination with Maternal and Child Health

The Title V Maternal and Child Health (MCH) programs are administered by the Arkansas Department of Health. Preventive health services are available to women, children, adolescents and families in 100 service sites in the state's 75 counties. Preventive services provided include well child screens, immunizations, prenatal care, family planning, hearing and vision screening, newborn screening, blood lead screening and follow-up. Over 250,000 Arkansans receive some level of Title V MCH services each year. Services to children with Special Health Care Needs are coordinated with DHS.

Section 3. Methods of Delivery and Utilization Controls (Section 2102)(a)(4))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 4.

3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children. Include a description of the choice of financing and the methods for assuring delivery of the insurance products and delivery of health care services covered by such products to the enrollees, including any variations. **(Section 2102)(a)(4) (42CFR 457.490(a))**

The utilization controls will be the same as under Title XIX.

3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children. Describe the systems designed to ensure that enrollees receiving health care services under the state plan receive only appropriate and medically necessary health care consistent with the benefit package described in the approved state plan. **(Section 2102)(a)(4) (42CFR 457.490(b))**

The utilization controls will be the same as under Title XIX.

Section 4. Eligibility Standards and Methodology. (Section 2102(b))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan,** and continue on to Section 5.

4.1. The following standards may be used to determine eligibility of targeted low-income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. **(Section 2102)(b)(1)(A)) (42CFR 457.305(a) and 457.320(a))**

4.1.1. ☒ Geographic area served by the Plan:

Statewide.

4.1.2. ☒ Age:

Conception to age 19; conception-to-birth enrollees are covered in the separate child health program; birth to 19 are covered in the Medicaid expansion.

4.1.3. ☒ Income:

At or below 200% FPL.

4.1.4. ☒ Resources (including any standards relating to spend downs and disposition of resources):

The resource test for the separate child health program is the same as applied to the SOBRA pregnant women category under Medicaid. There is no resource test for the Medicaid expansion.

4.1.5. ☒ Residency (so long as residency requirement is not based on length of time in state):

Enrollees must be current Arkansas residents with the intent to remain in the State.

4.1.6. ☐ Disability Status (so long as any standard relating to disability status does not restrict eligibility):

Not applicable.

4.1.7. ☒ Access to or coverage under other health coverage:

SCHIP enrollees cannot be eligible for Medicaid. SCHIP enrollees cannot have access to a state health benefits program. ARKids B enrollees cannot be covered under a group health plan; enrollees in the separate child health program (unborn child) may not have health insurance that covers pregnancy related services.

4.1.8. ☒ Duration of eligibility:

Same as Medicaid.

4.1.9. ☒ Other standards (identify and describe):

A Social Security Number is required for Medicaid expansion enrollees. There no SSN requirement for the separate child health program to cover unborn children.

4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: **(Section 2102)(b)(1)(B)) (42CFR 457.320(b))**

4.2.1. ☒ These standards do not discriminate on the basis of diagnosis.

4.2.2. ☒ Within a defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.

4.2.3. ☒ These standards do not deny eligibility based on a child having a pre-existing medical condition.

4.3. Describe the methods of establishing eligibility and continuing enrollment. **(Section 2102)(b)(2)) (42CFR 457.350)**

The methods of establishing eligibility and continuing enrollment are the same as under Title XIX.

4.3.1 Describe the state's policies governing enrollment caps and waiting lists (if any). **(Section 2106(b)(7)) (42CFR 457.305(b))**

☒ Check here if this section does not apply to your state.

4.4. Describe the procedures that assure that:

4.4.1. Through the screening procedures used at intake and follow-up eligibility determination, including any periodic redetermination, that only targeted low-income children who are ineligible for Medicaid or not covered under a group health plan or health insurance coverage (including access to a state health benefits plan) are furnished child health assistance under the state child health plan. (Sections 2102(b)(3)(A) and 2110**(b)(2)(B)) (42 CFR 457.310(b) (42CFR 457.350(a)(1)) 457.80(c)(3))**

Medicaid Expansion: At eligibility determination and redetermination, applications are reviewed for coverage under a group health plan. ARKids B children who meet Medicaid eligibility criteria and those whose parents are state employees are coded in the system; these children are funded by Medicaid – they are not funded by SCHIP.

State Children's Health Program: At eligibility determination and redetermination, applications are reviewed for coverage under a group health plan or health insurance coverage, that covers pregnancy related services, for access to a state health benefits plan and for Medicaid eligibility prior to enrollment in the State's separate child health program.

4.4.2. The Medicaid application and enrollment process is initiated and facilitated for children found through the screening to be potentially eligible for medical assistance under the state Medicaid plan under Title XIX. **(Section 2102)(b)(3)(B)) (42CFR 457.350(a)(2))**

Medicaid Expansion: The ARKids First application is a combined application for ARKids A (Medicaid) and ARKids B (Medicaid 1115 demonstration). Reference 2.3 above for more information related to the screening process.

State Children's Health Program: Screening procedures identify any applicant or enrollee who would be potentially eligible for Medicaid services based on the eligibility of his or her mother under one of the poverty level groups described in section 1902 (1) of the Act, section 1931 of the Act, or a Medicaid demonstration project approved under section 1115 of the Act.

4.4.3. The State is taking steps to assist in the enrollment in SCHIP of children determined ineligible for Medicaid. **(Sections 2102(a)(1) and (2) and 2102(c)(2)) (42CFR 431.636(b)(4))**

Medicaid Expansion: The ARKids First application is a combined application for ARKids A (Medicaid) and ARKids B (Medicaid 1115 demonstration). Reference 2.3 above for more information related to the screening process.

State Children's Health Program: Any applicant or enrollee who is found ineligible for Medicaid services (based on the eligibility of his or her mother) is automatically reviewed for SCHIP Medicaid expansion or separate child health plan eligibility.

4.4.4 The insurance provided under the state child health plan does not substitute for coverage under group health plans. Check the appropriate box. **(Section 2102)(b)(3)(C)) (42CFR 457.805) (42 CFR 457.810(a)-(c))**

4.4.4.1. ☒ Coverage provided to children in families at or below 200% FPL: describe the methods of monitoring substitution.

Medicaid Expansion: The uninsured requirement for ARKids B (Medicaid and SCHIP) is that the child must have been uninsured for a minimum of six months to prevent substitution of coverage.

State Child Health Insurance Program: Coverage for the unborn child covers only those who do not qualify for Medicaid although the income and resource limit is the same as the SOBRA pregnant women's Medicaid category; the difference is that the unborn child coverage does not require the pregnant woman to meet Medicaid citizenship requirements. The state child health program requires that the pregnant woman has no health insurance coverage for the pregnancy. Also the unborn child benefit package is limited to services related to the pregnancy and is of a temporary nature. Due to the above factors, the State does not think there will be substitution of coverage.

4.4.4.2. ☐ Coverage provided to children in families over 200% and up to 250% FPL: describe how substitution is monitored and identify specific strategies to limit substitution if levels become unacceptable.

4.4.4.3. ☐ Coverage provided to children in families above 250% FPL: describe how substitution is monitored and identify specific strategies in place to prevent substitution.

4.4.4.4. ☐ If the state provides coverage under a premium assistance program, describe:

The minimum period without coverage under a group health plan, including any allowable exceptions to the waiting period.

The minimum employer contribution.

The cost-effectiveness determination.

4.4.5 Child health assistance is provided to targeted low-income children in the state who are American Indian and Alaska Native. **(Section 2102)(b)(3)(D)) (42 CFR 457.125(a))**

American Indian and Alaska Native children are eligible for Arkansas' SCHIP Medicaid expansion or separate child health program on the same basis as any other children in the State, regardless of whether they may be eligible for or served by Indian Health Services-funded care.

Section 5. Outreach (Section 2102(c))

Describe the procedures used by the state to accomplish:

Outreach to families of children likely to be eligible for child health assistance or other public or private health coverage to inform them of the availability of the programs, and to assist them in enrolling their children in such a program: **(Section 2102(c)(1)) (42CFR 457.90)**

Arkansas developed a comprehensive outreach strategy for ARKids B. The strategy applies equally to the title XIX and the SCHIP components of ARKids B*. Outreach for the separate child health insurance program is through the ConnectCare contract with ADH and through the ADH pregnant women's program, including presumptive eligibility.*

Media Campaign

In addition to the regular Medicaid outreach, Arkansas developed outreach geared specifically to the ARKids B Program. Governor Mike Huckabee held a gala press conference on September 11, 1997, to launch the ARKids B* Program. This has been followed by an extensive media campaign, including television, radio, print, and distribution of brochures in such places as McDonald's® food sacks. A key factor in the success of this campaign to date has been the active role Governor Huckabee has taken by appearing in television and radio public service announcements, as well as in the printed materials and on the ARKids B website: www.ARKidsfirst.com.*

* *The media campaign has been modified to incorporate the changes in the use of the ARKids First name; ARKids First is now composed of ARKids A (Medicaid) and ARKids B, the 1115 demonstration. The SCHIP eligibles will be part of the ARKids B component.*

Coordination With Public and Private Entities

The outreach effort has been further advanced by working in cooperation with a broad range of public and private entities. These include Arkansas Children's Hospital (they co-sponsored an ARKids First (ARKids B) newspaper insert with DHS), Arkansas Advocates for Children and Families, and several public schools, day care centers, hospitals, clinics, churches, and community centers. Arkansas Department of Human Services (DHS) county offices have widely distributed ARKids First application forms to these organizations. Arkansas Advocates for Children and Families has been particularly instrumental in providing outreach by successfully writing a foundation grant proposal to conduct targeted outreach efforts in key parts of the state.

A supply of ARKids First applications was given to the Arkansas Department of Health (ADH) for distribution in their WIC clinics and to give to pregnant women for whom they are establishing presumptive eligibility in the Pregnant Women, Infants and Children category of Medicaid (SOBRA). ADH will be a primary intake point for the separate child health insurance program.

Contracts

A. Contract with Arkansas Advocates for Children and Families

The State has a contract with Arkansas Advocates for Children and Families, the State's leading child advocacy agency, to provide a targeted outreach campaign for ARKids First (ARKids A and both the Title XIX and SCHIP components of ARKids B). This organization has an established statewide network of local community resources such as local Health Community Coalitions, volunteers, schools, and other organizations, which are in daily contact with the targeted population, to perform outreach. This contract targets working families and families who are less likely to have been exposed to the direct media campaign, and more likely to face barriers to health care access (e.g., employment restrictions, inadequate or no transportation, language and /or communication barriers). Examples of how the outreach system functions include the following:

- *Training sessions with local coalitions made up of community health care centers, private health care providers, school district personnel, local businesses and Chambers of Commerce, and faith-based organizations.*
- *Setting up information tables/booths at school, city or county health fairs and other special events.*
- *Gathering information for local coalition members and program recipients about ways to eliminate real or perceived barriers to access.*

B. Contract with the Arkansas Department of Health

The State also has a contract with the Arkansas Department of Health (ADH) to provide information to recipients/applicants through a media campaign and a 24 hour toll-free telephone Help Line Service. The Help Line Service responds to questions received from Medicaid and ARKids First (ARKids A and ARKids B) applicants/recipients and providers by telephone concerning eligibility, access, enrollment, rights and responsibilities and other issues. The ADH media campaign publicizes the telephone Help Line, promotes appropriate usage of the medical care system, and uses the most cost-effective strategies, as determined by ADH with DHS approval. The campaign may include television and radio advertising, direct mail, print media, telemarketing and other viable methods that target children.

Website

The ARKids First website address is www.arkidsfirst.com. The site has six subject links: 1) eligibility, 2) questions, 3) apply, (this includes an application in English or Spanish which can be printed from the website), 4) benefits, 5) more information, and 6) other services.

The Arkansas Medicaid website is located at www.medicaid.state.ar.us. This site contains a link to the ARKids First site.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children: (Check all that apply.) **(42CFR 457.410(a))**

6.1.1. ☐ Benchmark coverage; **(Section 2103(a)(1) and 42 CFR 457.420)**

6.1.1.1. ☐ FEHBP-equivalent coverage; **(Section 2103(b)(1))** (If checked, attach copy of the plan.)

6.1.1.2. ☐ State employee coverage; **(Section 2103(b)(2))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.1.3. ☐ HMO with largest insured commercial enrollment **(Section 2103(b)(3))** (If checked, identify the plan and attach a copy of the benefits description.)

6.1.2. ☐ Benchmark-equivalent coverage; **(Section 2103(a)(2) and 42 CFR 457.430)** Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach a signed actuarial report that meets the requirements specified in 42 CFR 457.431**. See instructions.**

6.1.3. ☐ Existing Comprehensive State-Based Coverage; **(Section 2103(a)(3) and 42 CFR 457.440)** [Only applicable to New York; Florida; Pennsylvania] Please attach a description of the benefits package, administration, date of enactment. If existing comprehensive state-based coverage is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value as of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for existing comprehensive state-based coverage.

6.1.4. ☒ Secretary-Approved Coverage. **(Section 2103(a)(4)) (42 CFR 457.450)**

6.1.4.1. ☒ Coverage the same as Medicaid State plan

Conception through birth: the State covers the same services that it covers in the Medicaid state plan for SOBRA pregnant women.

6.1.4.2. ☒ Comprehensive coverage for children under a Medicaid Section 1115 demonstration project

Birth through age 18: the coverage is the secretary approved benefit package for the ARKids B 1115 demonstration.

6.1.4.3. ☐ Coverage that either includes the full EPSDT benefit or that the state has extended to the entire Medicaid population

6.1.4.4. ☐ Coverage that includes benchmark coverage plus additional coverage

6.1.4.5. ☐ Coverage that is the same as defined by existing comprehensive state-based coverage.

6.1.4.6. ☐ Coverage under a group health plan that is substantially equivalent to or greater than benchmark coverage through a benefit by benefit comparison (Please provide a sample of how the comparison will be done)

6.1.4.7. ☐ Other (Describe)

6.2. The state elects to provide the following forms of coverage to children:
(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) **(Section 2110(a)) (42CFR 457.490)**

For the unborn child, the State covers pregnancy related services and services that if not treated could complicate the pregnancy, i.e., the State covers the same services that it covers for the Medicaid SOBRA pregnant women category. For the SCHIP Medicaid expansion child, birth through 18, the State covers the following:

6.2.1. ☒ Inpatient services **(Section 2110(a)(1))**

Primary Care Physician (PCP) referral is required. Prior authorization is required on stays over 4 days, per admission; must meet medical necessity.

6.2.2. ☒ Outpatient services **(Section 2110(a)(2))**

A PCP referral and medical necessity are required. Outpatient hospital benefits do not include take home drugs and supplies. (See prescription drugs, 6.2.6, and disposable medical supplies, 6.2.13)

6.2.3. ☒ Physician services **(Section 2110(a)(3))**

Based on medical necessity. A PCP referral is required for a specialist, and for inpatient professional services.

6.2.4. ☒ Surgical services **(Section 2110(a)(4))**

PCP referral is required. Coverage is for medically necessary surgery as follows: office, inpatient hospital, outpatient hospital or ambulatory surgical center. For some surgeries, the procedure must be performed on an *outpatient basis unless the physician receives approval for inpatient surgical services.*

6.2.5. ☒ Clinic services (including health center services) and other ambulatory health care services. **(Section 2110(a)(5))**

A PCP referral and medical necessity are required. Clinic services are covered in Ambulatory Surgical Centers, Federally Qualified Health Centers and Rural Health Clinics.

6.2.6. ☒ Prescription drugs **(Section 2110(a)(6))**

Medical necessity and a prescription are required. There is no limit on the number of prescriptions per month. Family planning prescriptions are unlimited. Pharmacists must fill prescriptions with a generic drug unless the brand name is the only one available or the prescribing physician certifies that the brand name is medically necessary.

6.2.7. ☒ Over-the-counter medications **(Section 2110(a)(7))**

A selected list of over-the-counter medications is covered, with a prescription.

6.2.8. ☒ Laboratory and radiological services **(Section 2110(a)(8))**

Medical necessity and a PCP referral are required.

6.2.9. ☒ Prenatal care and prepregnancy family services and supplies **(Section 2110(a)(9))**

Medical necessity is required. A PCP referral is not required. Family planning is limited as follows: one basic family planning visit, and three follow-up visits per state fiscal year (July 1 – June 30).

6.2.10. ☒ Inpatient mental health services, other than services described in 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services **(Section 2110(a)(10))**

Medical necessity and PCP referral are required. Currently this service is covered only in an acute care hospital; it is not provided in an inpatient psychiatric category of service. There is no limit on the number of days. Substance abuse treatment will be included only when the primary diagnosis is mental health.

Arkansas does not have any Institutions for Mental Diseases.

6.2.11. ☒ Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services **(Section 2110(a)(11)**

Medical necessity and PCP referral are required.

Substance abuse treatment will be included when the primary diagnosis is mental health.

6.2.12. ☒ Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) **(Section 2110(a)(12))**

Services must be medically necessary. Coverage includes prosthetic devices. A PCP referral and prescription are required. The DME limit is $500 per state fiscal year (July 1 – June 30).

Eyeglasses are covered separately – see "Other Services".

6.2.13. ☒ Disposable medical supplies **(Section 2110(a)(13))**

Must be medically necessary and a PCP prescription is required; limited to $125 per month. A benefit extension may be granted, if medically necessary.

6.2.14. ☐ Home and community-based health care services (See instructions) **(Section 2110(a)(14))**

6.2.15. ☒ Nursing care services (See instructions) **(Section 2110(a)(15))**

Medical necessity and a PCP referral are required. Nurse practitioners and certified nurse midwifes are covered.

6.2.16. ☒ Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest **(Section 2110(a)(16)**

Must be medically necessary and prior authorization is required. A PCP referral is not required.

6.2.17. ☒ Dental services **(Section 2110(a)(17))**

Dental services are limited to: routine dental care; one initial oral exam, bite-wings, scalings and prophlaxis/fluoride treatment per state fiscal year (SFY July 1 – June 30); one dental screen per SFY (subsequent screen provided with medical necessity).

Oral surgery is covered under physician's services and is based upon medical necessity.

6.2.18. ☒ Inpatient substance abuse treatment services and residential substance abuse treatment services **(Section 2110(a)(18))**

Inpatient substance abuse treatment services are combined with mental health services. See 6.2.10

6.2.19. ☒ Outpatient substance abuse treatment services **(Section 2110(a)(19))**

Outpatient substance abuse treatment services are combined with mental health services. See 6.2.11.

6.2.20. ☐ Case management services **(Section 2110(a)(20))**

6.2.21. ☐ Care coordination services **(Section 2110(a)(21))**

6.2.22. ☒ Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders **(Section 2110(a)(22))**

Speech therapy must be medically necessary and a PCP referral is required. There is no limit on speech therapy, as long as it is medically necessary and there is a PCP referral.

Physical and Occupational therapy are NOT covered.

6.2.23. ☐ Hospice care **(Section 2110(a)(23))**

6.2.24. ☐ Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) **(Section 2110(a)(24))**

6.2.25. ☐ Premiums for private health care insurance coverage **(Section 2110(a)(25))**

6.2.26. ☒ Medical transportation **(Section 2110(a)(26))**

Medical necessity is required, however PCP referral is not required. Coverage is for ambulance only (emergency only).

6.2.27. ☐ Enabling services (such as transportation, translation, and outreach services (See instructions) **(Section 2110(a)(27))**

6.2.28. ☒ Any other health care services or items specified by the Secretary and not included under this section **(Section 2110(a)(28))**

OTHER SERVICES (Birth through 18)

Chiropractor: Medical necessity and PCP are required. Covers only manipulation of the spine to correct a dislocation, and an X-ray, when necessary.

Emergency Department Services: Medical necessity is required. PCP referral is not required for an emergency, but is required for non-emergency services provided in an emergency department.

Eyeglasses: One pair every 12 months, if medically indicated. A PCP referral is ***not*** *required.*

Home Health: Ten visits per State Fiscal Year. Home Health services may be provided by a registered nurse or a licensed practical nurse, or a combination of the two.

Immunizations: ARKids B uses the schedule of immunizations approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

Podiatry: Medical necessity and a PCP referral are required.

Preventive Health Screenings: Preventive health screenings, which are performed at the intervals recommended by the American Academy of Pediatrics, are covered. The PCP must complete the screen or make a referral for the screen.

Vision: One routine eye exam (refraction) every 12 months.

EXCLUDED SERVICES (Birth through 18)

Audiological Services
Child Health Management Services
Developmental Day Treatment Clinic Services
Diapers, Underpads and Incontinence Supplies
Domiciliary Care
End Stage Renal Disease
Hearing Aids
Hospice
Hyperalimentation
Inpatient Psychiatric Services for Under Age 21
Non-emergency Transportation
Nursing Facilities
Occupational Therapy
Orthodontia
Orthotic Appliances
Personal Care
Physical Therapy
Private Duty Nursing Services
Prosthetic Devices
Rehabilitative Services for Persons with Physical Disabilities
Rehabilitative Therapy for Chemical Dependency
Targeted Case Management
Ventilator Services

6.3 The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan: **(42CFR 457.480)**

6.3.1. ☒ The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services **(Section 2102(b)(1)(B)(ii))**; **OR**

6.3.2. ☐ The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.4.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPAA/ERISA **(Section 2103(f))**. Please describe: *Previously 8.6*

6.4 **Additional Purchase Options.** If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate option. To be approved, the state must address the following: **(Section 2105(c)(2) and(3)) (42 CFR 457.1005 and 457.1010)**

6.4.1. ☐ Cost **Effective Coverage.** Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs incurred by the state to administer the plan, if it demonstrates the following **(42CFR 457.1005(a))**:

6.4.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; **Describe the coverage provided by the alternative delivery system**. **The state may cross reference section 6.2.1 - 6.2.28.** **(Section 2105(c)(2)(B)(i)) (42CFR 457.1005(b))**

6.4.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; **Describe the cost of such coverage on an average per child basis**. **(Section 2105(c)(2)(B)(ii)) (42CFR 457.1005(b))**

6.4.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(c)(5)(F) or 1923 of the Social Security Act. **Describe the community based delivery system.** **(Section 2105(c)(2)(B)(iii)) (42CFR 457.1005(a))**

6.4.2. ☐ **Purchase of Family Coverage.** Describe the plan to purchase family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children, if it demonstrates the following: **(Section 2105(c)(3)) (42CFR 457.1010)**

6.4.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and **(Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.)** **(Section 2105(c)(3)(A)) (42CFR 457.1010(a))**

6.4.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. **(Section 2105(c)(3)(B)) (42CFR 457.1010(b))**

6.4.2.3. The state assures that the coverage for the family otherwise meets title XXI requirements. **(42CFR 457.1010(c))**

Section 7. Quality and Appropriateness of Care

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 8.

7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. **(2102(a)(7)(A)) (42CFR 457.495(a))**

Will the state utilize any of the following tools to assure quality?
(Check all that apply and describe the activities for any categories utilized.)

The methods used to assure quality and appropriateness of care, are the same as under Title XIX.

7.1.1. ☐ Quality standards
7.1.2. ☐ Performance measurement
7.1.3. ☐ Information strategies
7.1.4. ☐ Quality improvement strategies

7.2. Describe the methods used, including monitoring, to assure: **(2102(a)(7)(B)) (42CFR 457.495)**

The methods used to assure quality and appropriateness of care, are the same as under Title XIX.

7.2.1 Access to well-baby care, well-child care, well-adolescent care and childhood and adolescent immunizations. **(Section 2102(a)(7)) (42CFR 457.495(a))**

The methods used to monitor and assure access to care, including well-care, are the same as under Title XIX.

7.2.2 Access to covered services, including emergency services as defined in 42 CFR 457.10. **(Section 2102(a)(7)) 42CFR 457.495(b))**

The methods used to monitor and assure access to care, including emergency services, are the same as under Title XIX.

7.2.3 Appropriate and timely procedures to monitor and treat enrollees with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition and access to out-of-network providers when the network is not adequate for the enrollee's medical condition. **(Section 2102(a)(7)) (42CFR 457.495(c))**

The methods used to monitor and treat enrollees "with chronic, complex, or serious medical conditions, including access to an adequate number of visits to specialists experienced in treating the specific medical condition", are the same as under Title XIX.

7.2.4 Decisions related to the prior authorization of health services are completed in accordance with state law **or,** in accordance with the medical needs of the patient, within 14 days after the receipt of a request for services. **(Section 2102(a)(7)) (42CFR 457.495(d))**

Decisions related to the prior authorization of health services are in accordance with Title XIX.

Section 8. Cost Sharing and Payment **(Section 2103(e))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**, and continue on to Section 9.

8.1. Is cost-sharing imposed on any of the children covered under the plan? **(42CFR 457.505)**

8.1.1. ☒ YES

Cost sharing is required in the Medicaid expansion for children from birth through age 18. However, no cost sharing is required in the separate child health insurance program that covers the unborn child.

8.1.2. ☐ NO**, skip to question 8.8.**

8.2. Describe the amount of cost-sharing, any sliding scale based on income, the group or groups of enrollees that may be subject to the charge and the service for which the charge is imposed or time period for the charge, as appropriate.
(Section 2103(e)(1)(A)) (42CFR 457.505(a), 457.510(b) &(c), 457.515(a)&(c))

8.2.1. Premiums: *N/A*
8.2.2. Deductibles: *N/A*
8.2.4. Other:

Medicaid Expansion:
Many services require a small coinsurance or copayment. The amount is the same for all ARKids B enrollees (Medicaid and SCHIP Medicaid expansion). The coinsurance is 20% of the Medicaid allowed amount per item for Durable Medical Equipment; and 20% of the Medicaid amount for the first Medicaid inpatient day for hospitalization. The copayment is $10.00 per medical visit; and $5.00 per prescription (must use generic and rebate manufacturer, if available).

Well-health care services are exempt from cost sharing.

Separate Child Health Insurance Program (unborn child):
There is no cost-sharing requirement.

8.3. Describe how the public will be notified, including the public schedule, of this cost-sharing (including the cumulative maximum) and changes to these amounts and any differences based on income. **(Section 2103(e)((1)(B)) (42CFR 457.505(b))**

Medicaid Expansion:
The cost sharing requirements for ARKids B (including the Medicaid expansion) are published on the ARKids B web site. The public is notified in advance via public notice when cost sharing requirements change.

State Child Health Insurance Program:
N/A. There are no cost-sharing requirements.

8.4. The state assures that it has made the following findings with respect to the cost sharing in its plan: **(Section 2103(e))**

Cost-sharing applies only to the SCHIP Medicaid expansion children. These children are included in the ARKids B Medicaid 1115 demonstration, in which the secretary approved cost-sharing requirements apply to all eligibles.

There are no cost-sharing requirements for the State Child Health Insurance Program coverage of the unborn child.

8.4.1. ☒ Cost-sharing does not favor children from higher income families over lower income families. **(Section 2103(e)(1)(B)) (42CFR 457.530)**

8.4.2. ☒ No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. **(Section 2103(e)(2)) (42CFR 457.520)**

8.4.3 ☒ No additional cost-sharing applies to the costs of emergency medical services delivered outside the network. **(Section 2103(e)(1)(A)) (42CFR 457.515(f))**

8.5. Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's income for the length of the child's eligibility period in the State. Include a description of the procedures that do not primarily rely on a refund given by the state for overpayment by an enrollee: **(Section 2103(e)(3)(B)) (42CFR 457.560(b) and 457.505(e))**

The cost-sharing rules, which were approved by CMS for the ARKids B Medicaid 1115 demonstration, are applied to the Medicaid expansion.

8.6 Describe the procedures the state will use to ensure American Indian (as defined by the Indian Health Care Improvement Act of 1976) and Alaska Native children will be excluded from cost-sharing. **(Section 2103(b)(3)(D)) (42CFR 457.535)**

The cost-sharing rules, which were approved by CMS for the ARKids B Medicaid 1115 demonstration, are applied to the Medicaid expansion.

8.7 Please provide a description of the consequences for an enrollee or applicant who does not pay a charge. **(42CFR 457.570 and 457.505(c))**

N/A. Neither premiums nor deductibles are required. The only recipient cost-sharing is paid by the recipient to the provider at the point of service.

8.7.1 Please provide an assurance that the following disenrollment protections are being applied:

N/A. The State does not disenroll children for reasons related to cost-sharing.

☐ State has established a process that gives enrollees reasonable notice of and an opportunity to pay past due premiums, copayments, coinsurance, deductibles or similar fees prior to disenrollment. **(42CFR 457.570(a))**

The State does not disenroll recipients due to not meeting cost sharing requirements.

☐ The disenrollment process affords the enrollee an opportunity to show that the enrollee's family income has declined prior to disenrollment for non payment of cost-sharing charges. **(42CFR 457.570(b))**

The State does not disenroll recipients due to not meeting cost sharing requirements.

☐ In the instance mentioned above, that the state will facilitate enrolling the child in Medicaid or adjust the child's cost-sharing category as appropriate. **(42CFR 457.570(b))**

The State does not disenroll recipients due to not meeting cost sharing requirements.

☒ The state provides the enrollee with an opportunity for an impartial review to address disenrollment from the program. **(42CFR 457.570(c))**

8.8 The state assures that it has made the following findings with respect to the payment aspects of its plan: **(Section 2103(e))**

8.8.1. ☒ No Federal funds will be used toward state matching requirements. **(Section 2105(c)(4)) (42CFR 457.220)**

8.8.2. ☒ No cost-sharing (including premiums, deductibles, copays, coinsurance and all other types) will be used toward state matching requirements. **(Section 2105(c)(5) (42CFR 457.224)** (*Previously 8.4.5)*

8.8.3. ☒ No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a provision limiting this obligation because the child is eligible under the this title. **(Section 2105(c)(6)(A)) (42CFR 457.626(a)(1))**

8.8.4. ☒ Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. **(Section 2105(d)(1)) (42CFR 457.622(b)(5))**

8.8.5. ☒ No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. **(Section 2105)(c)(7)(B)) (42CFR 457.475)**

8.8.6. ☒ No funds provided under this title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except as described above). **(Section 2105)(c)(7)(A)) (42CFR 457.475)**

Section 9. Strategic Objectives and Performance Goals and Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: **(Section 2107(a)(2)) (42CFR 457.710(b))**

I. The infrastructure of the Arkansas Department of Human Services, Division of Medical Services and Division of County Operations, will be able to accommodate all critical facets of Arkansas' Title XXI program.

II. Low-income children who were previously without health insurance coverage will have health insurance coverage through Arkansas' Title XXI Program. Previously uninsured children who may be potentially eligible for Arkansas' Title XXI Program will be identified through ongoing outreach activities.

III. Children enrolled in Arkansas' Title XXI Program will have access to health care.

IV. Arkansas' Title XXI Program will improve the health status of children enrolled in the program as well as improve the overall health care system accessed through the program.

9.2. Specify one or more performance goals for each strategic objective identified: **(Section 2107(a)(3)) (42CFR 457.710(c))**

Performance Goal for Objective I:

Effective upon implementation of the SCHIP state plan, the State will have in place: 1) data systems modifications with regard to screening for Medicaid, SCHIP eligibility determination, enrollment, participant information, health service utilization, billing, provider information, etc.; 2) personnel to implement SCHIP (i.e., eligibility workers, administrative staff, and support staff; and 3) existing and new cases will be coded to the system to identify the case as either Title XIX or Title XXI.

Performance Goal for Objective II:

Mechanisms to conduct outreach have been developed and implemented, and are ongoing. The outreach does not specifically reference SCHIP since the SCHIP Medicaid expansion program is part of ARKids B and the separate child health insurance program to cover unborn children will be linked to the Medicaid SOBRA pregnant women category. However, the outreach is specifically geared toward families whose family income is at or below 200% of the federal poverty level. This, of course, includes the SCHIP population. Please reference section 5, above.

Performance Goal for Objective III:

As children are enrolled in the SCHIP component of ARKids B, their parents will be asked to select a primary care physician (PCP) of their choice. As pregnant women are enrolled in the state health insurance program for coverage of their unborn child, they will be asked to select a PCP. The Division of Medical Services' Primary Care Case Management Program, ConnectCare, offers over 1800 physicians statewide, who have caseload availability of approximately 1,000,000 patients. Access availability is five to one. ConnectCare will apply equally to the Title XIX and Title XXI children.

Performance Goal for Objective IV:
Upon implementation of the SCHIP state plan, the health status of the children in the SCHIP Medicaid expansion and in the separate state child health insurance program will be improved through increased access to the health care system and through having a health care home. Also the ConnectCare program provides information that promotes preventive health care.

9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:
(Section 2107(a)(4)(A),(B)) (42CFR 457.710(d))

Measurement of Performance Goal for Objective I:
The State will monitor the data system to ensure that current cases were converted and new cases are assigned to the Title XXI and Title XIX components, as appropriate. Statistical and financial reports will be generated which will reflect cases and expenditures in each component of ARKids B and for the SCHIP unborn child group. The State will also monitor timeliness and quality of case processing.

Measurement of Performance Goal for Objective II:
Weekly, monthly and quarterly management reports will be used to measure enrollment in ARKids B (Titles XIX and XXI) and in the separate state child health insurance program.

Measurement of Performance Goal for Objective III:
Arkansas Medicaid's Primary Care Case Management Program, Connect Care, has in place an extensive quality evaluation plan (QEP) operated through the Arkansas Foundation for Medical Care, Inc. (AFMC), the state certified Quality Improvement Organization (QIO). The purpose of the QEP is to improve the quality of services to Medicaid and Title XXI recipients within the ConnectCare program resulting in an overall improvement of the recipient's health status. Arkansas will also measure performance through claims data and individual PCP performance measurements.

Measurement of Performance Goal for Objective V:
AFMC measures health status, including immunizations and well child visits, based on both claims data and Arkansas Department of Health statistics (Titles XIX and XXI). Arkansas will also measure performance in the Medicaid expansion through an ARKids B recipient satisfaction survey.

Check the applicable suggested performance measurements listed below that the state plans to use: **(Section 2107(a)(4))**

9.3.1. ☒ The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.

9.3.2. ☒ The reduction in the percentage of uninsured children.

9.3.3. ☒ The increase in the percentage of children with a usual source of care.
9.3.4. ☐ The extent to which outcome measures show progress on one or more of the health problems identified by the state.
9.3.5. ☐ HEDIS Measurement Set relevant to children and adolescents younger than 19.
9.3.6. ☒ Other child appropriate measurement set. List or describe the set used.

Immunizations
Well child care
Adolescent well visits
Satisfaction with care

9.3.7. ☐ If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- 9.3.7.1. ☐ Immunizations
- 9.3.7.2. ☐ Well child care
- 9.3.7.3. ☐ Adolescent well visits
- 9.3.7.4. ☐ Satisfaction with care
- 9.3.7.5. ☐ Mental health
- 9.3.7.6. ☐ Dental care
- 9.3.7.7. ☐ Other, please list:

9.3.8. ☐ Performance measures for special targeted populations.

9.4. ☒ The state assures it will collect all data, maintain records and furnish reports to the Secretary at the times and in the standardized format that the Secretary requires. **(Section 2107(b)(1)) (42CFR 457.720)**

9.5. ☒ The state assures it will comply with the annual assessment and evaluation required under Section 10. Briefly describe the states plan for these annual assessments and reports. **(Section 2107(b)(2)) (42CFR 457.750)**

The State has an approved Section 1915(b) waiver for Primary Care Case Management (PCCM). The State is responsible for assessment and evaluation under the PCCM waiver and intends to use the same contract for the SCHIP Medicaid expansion and the separate state child health insurance program. The contractor evaluates data including number of office visits, continuity of care, and hospitalizations, etc.

9.6. ☒ The state assures it will provide the Secretary with access to any records or information relating to the plan for purposes of review of audit. **(Section 2107(b)(3)) (42CFR 457.720)**

9.7. ☒ The state assures that, in developing performance measures, it will modify those measures to meet national requirements when such requirements are developed. **(42CFR 457.710(e))**

9.8. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.135)**

9.8.1. ☒ Section 1902(a)(4)(C) (relating to conflict of interest standards)
9.8.2. ☒ Paragraphs (2), (16) and (17) of Section 1903(i) (relating to limitations on payment)
9.8.3. ☒ Section 1903(w) (relating to limitations on provider donations and taxes)
9.8.4. ☒ Section 1132 (relating to periods within which claims must be filed)

9.9 Describe the process used by the state to accomplish involvement of the public in the design and implementation of the plan and the method for insuring ongoing public involvement. **(Section 2107(c)) (42CFR 457.120(a) and (b))**

The ARKids B work group and the Arkansas Advocates for Children and Families agency agreed that Arkansas should pursue funding appropriate ARKids B children through Title XXI. The separate state child health insurance program to cover unborn children is supported by the Arkansas Advocates for Children and Families, the Arkansas Department of Health and the Arkansas Center for Health Improvement.

Changes in Medicaid expansion and the separate state child health insurance program will be promulgated as required by the State's Administrative Procedures Act (APA). The APA requires that the agency publish a notice, regarding proposed rules, in a newspaper with statewide circulation. As a part of the APA process, DMS also notifies "interested persons" and appropriate Medicaid providers of proposed rules to solicit comments and input. The APA process requires the review of new and revised rules by the Administrative Rules and Regulations Subcommittee of the Arkansas Legislative Council.

9.9.1 Describe the process used by the state to ensure interaction with Indian Tribes and organizations in the state on the development and implementation of the procedures required in 42 CFR ∋457.125. **(Section 2107(c)) (42CFR 457.120(c))**

There is no American Indian Nation, Tribe or reservation in Arkansas. However, we were able to locate a private-not-for-profit organization in Little Rock called the American Indian Center of Arkansas. They have agreed to cooperate with us in providing information to targeted low-income children who are Indians. We will provide them with ARKids First applications and pamphlets.

9.9.2 For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), please describe how and when prior public notice was provided as required in 457.65(b) through (d).

Amendments relating to eligibility or benefits, including cost sharing and enrollment procedures will be promulgated according to the State's Administrative Procedures Act. The Act requires a public notice in a statewide newspaper with a 30-day comment period.

9.10. Provide a one year projected budget. A suggested financial form for the budget is attached. The budget must describe: **(Section 2107(d)) (42CFR 457.140)**

- Planned use of funds, including --
  - Projected amount to be spent on health services;
  - Projected amount to be spent on administrative costs, such as outreach, child health initiatives, and evaluation; and
  - Assumptions on which the budget is based, including cost per child and expected enrollment.
- Projected sources of non-Federal plan expenditures, including any requirements for cost-sharing by enrollees.

The source of the non-Federal share is State General Revenue.

SCHIP Budget Plan Template

	Federal Fiscal Year Costs
Enhanced FMAP rate	**82.31%** [1]
Benefit Costs	
Insurance payments	
Managed care	
per member/per month rate @ # of eligibles	$ 17,496.00
Fee for Service	$ 3,259,854.72
Total Benefit Costs	**$ 3,277,350.72** [2]
(Offsetting beneficiary cost sharing payments)	
Net Benefit Costs	
Administration Costs	
Outreach	$ 49,100.00
Reporting	$ 49,100.00
Quality Assurance	$ 25,000.00
Assessment	$ 28,300.00
Eligibility	$ 176,235.08
Other	
Total Administration Costs	**$ 327,735.08**
10% Administrative Cost Ceiling	$ 360,508.58
Federal Share (multiplied by SCHIP-FMAP rate)	$ 2,967,556.42
State Share	$ 637,529.38
TOTAL PROGRAM COSTS	**$ 3,605,085.80**[2]

See Attachments I and J for supporting documentation.

[1]*This is a weighted percentage (i.e., 3 months at 82.27% and 9 months at 82.32%).*
[2]*These program estimates are only for the coverage of unborn children.*

Section 10. Annual Reports and Evaluations (Section 2108)

10.1. Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: **(Section 2108(a)(1),(2)) (42CFR 457.750)**

10.1.1. ☒ The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and

10.2. ☒ The state assures it will comply with future reporting requirements as they are developed. **(42CFR 457.710(e))**

10.3. ☒ The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Section 11. **Program Integrity (Section 2101(a))**

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the states Medicaid plan**, and continue to Section 12.

11.1 ☒ The state assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. **(Section 2101(a)) (42CFR 457.940(b))**

11.2. The state assures, to the extent they apply, that the following provisions of the Social Security Act will apply under Title XXI, to the same extent they apply to a state under Title XIX: **(Section 2107(e)) (42CFR 457.935(b))** *The items below were moved from section 9.8. (Previously items 9.8.6. - 9.8.9)*

- 11.2.1. ☒ 42 CFR Part 455 Subpart B (relating to disclosure of information by providers and fiscal agents)
- 11.2.2. ☒ Section 1124 (relating to disclosure of ownership and related information)
- 11.2.3. ☒ Section 1126 (relating to disclosure of information about certain convicted individuals)
- 11.2.4. ☒ Section 1128A (relating to civil monetary penalties)
- 11.2.5. ☒ Section 1128B (relating to criminal penalties for certain additional charges)
- 11.2.6. ☒ Section 1128E (relating to the National health care fraud and abuse data collection program)

Section 12. Applicant and enrollee protections (Sections 2101(a))

☐ **Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan**.

Eligibility and Enrollment Matters

12.1 Please describe the review process for **eligibility and enrollment** matters that complies with 42 CFR 457.1120.

The review process for eligibility and enrollment matters is the same as the Medicaid Fair Hearing process.

Health Services Matters

12.2 Please describe the review process for **health services matters** that complies with 42 CFR 457.1120.

The review process for health service matters is the same as the Medicaid Fair Hearing process.

Premium Assistance Programs

12.3 If providing coverage through a group health plan that does not meet the requirements of 42 CFR 457.1120, please describe how the state will assure that applicants and enrollees have the option to obtain health benefits coverage other than through the group health plan at initial enrollment and at each redetermination of eligibility.

N/A